110TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 110–868
Part 1

BREAST CANCER PATIENT PROTECTION ACT OF 2008

SEPTEMBER 23, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 758]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 758) to require that health plans provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

69–006

AMENDMENT

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast Cancer Patient Protection Act of 2008".

SEC. 2. FINDINGS.

Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States;

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States;

(4) currently, 20 States mandate minimum hospital stay coverage after a patient undergoes a mastectomy;

(5) according to the American Cancer Society, there were 40,954 deaths due to breast cancer in women in 2004;

(6) according to the American Cancer Society, there are currently over 2.0 million women living in the United States who have been treated for breast cancer; and

(7) according to the American Cancer Society, a woman in the United States has a 1 in 8 chance of developing invasive breast cancer in her lifetime.

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

"SEC. 714. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

"(a) INPATIENT CARE.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

"(A) except as provided for in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

"(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

"(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

"(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

"(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

"(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

"(d) SECONDARY CONSULTATIONS.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

"(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

"(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

"(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

"(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d); or

"(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage solely for the purpose of avoiding the requirements of this section.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following:

"Sec. 714. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after the date that is 90 days after the date of enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

"SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

"(a) INPATIENT CARE.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

"(A) insofar as the attending physician, in consultation with the patient, determines it to be medically necessary—

"(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

"(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under this paragraph.

"(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

"(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

"(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

"(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

"(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

"(d) SECONDARY CONSULTATIONS.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

"(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

"(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

"(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

"(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d); or

"(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage solely for the purpose of avoiding the requirements of this section.".

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to group health plans for plan years beginning on or after 90 days after the date of enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended—

(1) by adding after section 2752 the following:

"SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

"The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market."; and

(2) by redesignating such subpart 3 as subpart 2.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

SEC. 6. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following:

"Sec. 9813. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.";

and

(2) by inserting after section 9812 the following:

"SEC. 9813. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

"(a) INPATIENT CARE.—

"(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan may not—

"(A) except as provided for in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

"(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

"(B) require that a provider obtain authorization from the plan for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

"(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

"(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

"(1) in the next mailing made by the plan to the participant or beneficiary; or

"(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

"(d) SECONDARY CONSULTATIONS.—

"(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

"(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

"(e) PROHIBITION ON PENALTIES.—A group health plan may not—

"(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

"(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

"(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d); or

"(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section.".

(b) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is amended by inserting after the item relating to section 9812 the following:

"Sec. 9813. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collec-

tive bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 7. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEWS OF CERTAIN NONRENEWALS AND DISCONTINUATIONS, INCLUDING RESCISSIONS, OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) CLARIFICATION REGARDING APPLICATION OF GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42) is amended—

(1) in its heading, by inserting "**, CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**" after "**GUARANTEED RENEWABILITY**";

(2) in subsection (a), by inserting ", including without rescission," after "continue in force"; and

(3) in subsection (b)(2), by inserting before the period at the end the following: ", including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed".

(b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

"(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

"(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply after the date of the enactment of this Act with respect to health insurance coverage issued before, on, or after such date.

PURPOSE AND SUMMARY

The purpose of H.R. 758, the Breast Cancer Patient Protection Act of 2007, is to guarantee that health insurers provide adequate coverage of hospital stays for persons undergoing mastectomies and other procedures related to breast cancer. It also provides additional protections to individuals whose insurer fails to renew, discontinues, or rescinds his or her policy. The bill amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code of 1986 (IRC) to prohibit health insurers from limiting benefits for mastectomies and breast conserving procedures to hospital stays of less than 48 hours; from limiting benefits for lymph node dissections for the treatment of breast cancer to hospital stays of less than 24 hours; and, from providing inducements or penalties to physicians to encourage the provision of benefits below those minimum amounts. The bill requires health insurers to provide access to secondary consultations to confirm or refute any initial diagnosis regarding breast cancer and requires disclosure of these provisions to plan participants.

In addition, the bill creates an independent review process for consumers in the individual health insurance market in the event

of non-renewal, discontinuation, or rescission of a health insurance policy. Insurers would be required to continue coverage under such policy until completion of the independent review.

BACKGROUND AND NEED FOR LEGISLATION

In general, regulation of group health plans and health insurance issuers providing health insurance coverage in connection with a group health plan occurs at the State level. All insurers are also subject to minimum protections provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Neither HIPAA nor the Employee Retirement Income Security Act of 1974 (ERISA) provide for guaranteed coverage of breast cancer treatment as specified in H.R. 758. Twenty States require minimum lengths of stay of some duration following mastectomies, while 30 States and the District of Columbia do not.[1] As a result, many people in the United States enroll in health insurance plans that are not required by law to provide adequate benefits to patients following invasive surgeries such as mastectomies, lumpectomies, and other procedures.

The Health Care Financing Administration in 1997 prohibited Medicare managed-care plans from setting maximum lengths of stay for mastectomies.[2] Similar instructions were given to Medicare's fee-for-service providers via the program's carriers and fiscal intermediaries.[3]

There is evidence that this variation in regulatory regimes affects the quality of care received by patients with breast cancer. One study found that 21 percent of Medicare fee-for-service patients aged 65–69 diagnosed with early-stage breast cancer had an outpatient mastectomy between the years 1998–2002, and found that "outpatient mastectomy, which could lower use of breast reconstruction, may raise concerns about whether patients receive adequate post-mastectomy care."[4] Another study found that "women with Medicare, Medicaid, or private commercial insurance were less likely to receive an outpatient mastectomy compared to women with an HMO payer." Additionally, the study found that State regulation affects the clinical level of care. Although clinical characteristics remain important, the State in which a woman receives care and whether she has an HMO payer are strong determinants of whether she receives an outpatient mastectomy.[5]

Numerous patient testimonials confirm the need for Federal legislation to guarantee minimum and adequate benefits for patients with breast cancer. At a May 21, 2008, hearing before the Subcommittee on Health of the Committee on Energy and Commerce, breast cancer patient Alva Williams testified that she had a mastectomy on March 6, 2006, and was sent home several hours after surgery. At the same hearing, Dr. Kristen Zarfos, a breast surgeon from Connecticut, testified that only six weeks prior to the hearing,

---

[1] Kaiser State Health Facts. http://www.statehealthfacts.org/comparemaptable.jsp?ind=489&cat=7.

[2] Operational Policy Letter No. 49, Office of Managed Care, OPL97.049 Feb. 12, 1997.

[3] Hearing of the Committee on Labor and Human Resources, U.S. Senate, March 6, 1997, p. 21–22.

[4] Bian, Krontiras, and Jeroan Allison, "Outpatient Mastectomy and Breast Reconstructive Surgery" Annals of Surgical Oncology 15:1032–1039, 2008.

[5] Case, Johantgen, and Steiner, "Outpatient Mastectomy: Clinical, Payer, and Geographic Influences." Health Services Research, October 2001.

she had been called by a woman in New Hampshire who was told she would have to go home a few hours after her surgery, despite being partially paralyzed and on blood thinning medication for blood clots. An online petition hosted by the television network Lifetime collected 20 million signatures in support of the legislation and numerous personal stories demonstrating its importance.

LEGISLATIVE AND EXECUTIVE HISTORY

Bills in the 104th–109th Congress.—The "Breast Cancer Patient Protection Act" was introduced in the 104th (H.R. 4296), 105th (H.R. 135), 106th (H.R. 116), 107th (H.R. 536), 108th (H.R. 1886), and 109th (H.R. 1849) Congress. The companion legislation before the Senate in the 110th Congress is S. 459. Companion legislation was introduced in the Senate in the 105th (S. 143), 106th (S. 681), 108th (S. 1684), and 109th (S. 910) Congress. Bills introduced prior to the 109th Congress only amended the Public Health Service Act and the Employee Retirement Income Security Act of 1974.

After the 109th Congress the introduced bills also applied the required benefits to the Internal Revenue Code of 1986, including H.R. 758, introduced during the 110th Congress. Each of these prior bills differs from H.R. 758, as amended, by the inclusion in H.R. 758 of additional protections relating to the individual health insurance market.

Patients' Bill of Rights.—H.R. 2563, passed by the House of Representatives in the 107th Congress, included a provision requiring health insurers to provide inpatient coverage for care following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer that is "medically necessary and appropriate" as determined by the attending physician, in consultation with the patient. It did not stipulate a minimum length of stay required to be covered by such an insurance plan. H.R. 2563 also required health insurers to provide coverage for a secondary consultation and prohibited certain inducements to attending physicians. The Senate-passed bill (S. 1052) provided the same protections, as did S. 1334, the Patients' Bill of Rights Plus Act, passed by the Senate in the 106th Congress. H.R. 3605, the Patients' Bill of Rights Act of 1998, passed by the House in the 105th Congress, provided the same minimum length of stay guarantees to patients undergoing mastectomies and lymph node dissections for the treatment of breast cancer as are provided in H.R. 758. S. 2330, the Patients' Bill of Rights Act, passed by the Senate in the 105th Congress, required insurers to cover lengths of stay as determined to be medically appropriate.

Administrative Actions.—The Health Care Financing Administration in 1997 prohibited Medicare managed care plans from setting maximum lengths of stay for mastectomies.[6] Similar instructions were given to fee-for-service providers via Medicare's carriers and fiscal intermediaries.[7]

[6] Operational Policy Letter No. 49, Office of Managed Care, OPL97.049 Feb. 12, 1997.

[7] Hearing of the Committee on Labor and Human Resources, U.S. Senate, March 6, 1997, p. 21–22.

State Legislation.—Twenty States have laws providing some guarantee of minimum hospital stays following mastectomies and other procedures to treat breast cancer.[8]

HEARINGS

On May 21, 2008, the Subcommittee on Health held a hearing on H.R. 758 and H.R. 1157, the Breast Cancer and Environmental Research Act of 2007. The witnesses included Dr. Deborah Winn, Associate Director of the National Cancer Institute's Epidemiology and Genetics Research Program; Ms. Fran Visco, President of the National Breast Cancer Coalition; Ms. Sheryl Crow, Singer, Songwriter, and Breast Cancer Advocate; Dr. Kim Lyerly, George Barth Geller Professor of Research in Cancer and Director of the Duke Comprehensive Cancer Center; Dr. Kristen Zarfos, Assistant Clinical Professor at the University of Connecticut School of Medicine and Director of the St. Francis Comprehensive Breast Health Center; and Ms. Alva Williams, a breast cancer patient.

COMMITTEE CONSIDERATION

On Wednesday, September 17, 2008, the full Committee met in open markup session and ordered H.R. 758 favorably reported to the House, amended, by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. No record votes were taken on amendments or in connection with ordering H.R. 758 reported to the House. A motion by Mr. Dingell to order H.R. 758 favorably reported to the House, amended, was agreed to by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Regarding clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Subcommittee on Health held a legislative hearing on H.R. 758, and the oversight findings of the Committee regarding the bill are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The purpose of H.R. 758 is to guarantee that health insurers provide adequate coverage of hospital stays for persons undergoing mastectomies and other procedures related to breast cancer and to provide additional protections to individuals in the individual health insurance market from non-renewal, discontinuation, and rescission of their policies.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Regarding compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 758

[8] Kaiser State Health Facts. http://www.statehealthfacts.org/comparemaptable.jsp?ind=489&cat=7.

would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARKS AND TAX AND TARIFF BENEFITS

Regarding compliance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 758 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 758 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate on H.R. 758 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 22, 2008.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 758, the Breast Cancer Protection Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Robert Stewart.

Sincerely,

ROBERT A. SUNSHINE
(For Peter R. Orszag, Director).

Enclosure.

H.R. 758—Breast Cancer Protection Act of 2007

H.R. 758 would require group health plans and health insurance issuers providing coverage in the group and non-group markets to ensure that inpatient coverage, outpatient coverage of lumpectomies, and radiation therapy are provided for breast cancer treatment. Group health plans and health insurance issuers would not be able to restrict benefits for any hospital length of stay related to mastectomies, lumpectomies, and other breast-conserving surgeries for the treatment of breast cancer to less than 48 hours. In addition, H.R. 758 would place the following requirements on group health plans and health insurance issuers:

- Group health plans and issuers would not be able to restrict benefits for any hospital length of stay related to lymph node dissections to less than 24 hours;
- Providers would not be required to get authorization from the plan to prescribe any length of stay that is within the requirements of H.R. 758;

• Group health plans and issuers would be required to notify their enrollees of this new coverage;
• Group health plans and issuers would also be required to offer full coverage for a secondary consultation by a specialist; and
• Group health plans and issuers would have to notify individuals before the non-renewal or discontinuation of coverage on the basis of fraud and provide an opportunity for review of such determination by an independent external third party under procedures determined by the Secretary of Health and Human Services.

CBO estimates that H.R. 758 would have no significant impact on federal spending or revenues.

H.R. 758 would impose private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). However, CBO estimates that the costs of complying with the new requirements would not exceed the threshold established in UMRA ($136 million in 2008, adjusted annually for inflation).

H.R. 758 would not impose an intergovernmental mandate as defined in the UMRA. An existing provision in the Public Health Service Act would allow state, local, and tribal governments, as employers that provide health benefits to their employees, to opt out of the requirements of this bill. Consequently, the requirements in the bill that establish minimum standards for providing consultation services and treatment benefits for individuals with breast cancer would not be intergovernmental mandates as defined in UMRA. The bill would affect the budgets of those governments only if they choose to comply with the requirements on group health plans.

The CBO staff contacts for this estimate are Robert Stewart (for federal costs), and Keisuke Nakagawa (for the private-sector impact). This estimate was approved by Keith J. Fontenot, Deputy Assistant Director for Health and Human Services, Budget Analysis Division.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 758 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 758.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for H.R. 758 is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian Tribes, and in the provisions of Article I, section 8, clause 1, that relate to expending funds to provide for the general welfare of the United States.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 758 does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act of 1995.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title of H.R. 758 as the Breast Cancer Patient Protection Act of 2008.

Section 2. Findings

Section 2 incorporates findings relating to breast cancer coverage in health insurance.

Section 3. Amendments to the Employee Retirement Income Security Act of 1974

Section 3 amends the Employee Retirement Income Security Act of 1974 relating to the group market. This section is not within the jurisdiction of the Committee.

Section 4. Amendments to the Public Health Service Act relating to the group market

Section 4 amends the Public Health Service Act with respect to group health plans and health insurance issuers providing health insurance coverage in connection with a group health plan that provide medical and surgical benefits.

(a) In general

The amendment made by subsection (a) requires such plans to provide certain coverage to breast cancer patients. Plans are to cover inpatient coverage (and in the case of a lumpectomy, outpatient coverage), and radiation therapy for breast cancer treatment. If determined to be medically necessary by the attending physician, in consultation with the patient, the section prohibits health plans from restricting hospital stays for mastectomy or breast-conserving surgery to less than 48 hours, or restricting hospital stays for lymph node dissection to less than 24 hours. The bill does not require patients to stay for the duration of the minimum lengths of stay if he or she chooses not to. The section prohibits health plans from requiring that a provider obtain authorization from the plan or the issuer for prescribing such lengths of stay.

H.R. 758 prohibits health plans from modifying the terms and conditions of coverage in the event that a patient chooses to obtain less than the minimum coverage required under this section. It also requires health plans to provide written and clear notice to each covered participant and beneficiary of the protections provided by the bill.

The bill requires coverage of a second opinion for breast cancer diagnosis regardless of the initial diagnosis. It assures that the terms and conditions under which a patient receives a second opinion are no more restrictive than those applicable to the initial consultations. If a physician certifies in writing that specialists currently operating within the patient's health plan cannot provide

the necessary second opinion, this legislation will ensure that patients are allowed to obtain a second opinion from an out-of-network specialist at no additional cost beyond what the patient would have paid in-network.

H.R. 758 prohibits health plans from financially penalizing a physician or specialist for providing the minimum care required in this section to a patient. It also precludes health plans from providing financial or other incentives to a physician or specialist to keep the length of hospital stay below the standards prescribed by this section or to limit referrals for second opinions.

(b) Effective dates

Subsection (b) provides that the requirements of this section take effect with respect to health plan years beginning 90 or more days after the date of enactment. For health plans covered by collective bargaining agreements the effective date is the start of the next collective bargaining agreement relating to the health plan (beginning 90 days after enactment). It allows for amendment of health plans agreed to by collective bargaining to include the requirements of this section without such collective bargaining agreement being considered terminated.

Section 5. Amendment to the Public Health Service Act relating to the individual market

Section 5 amends the Public Health Service Act with respect to individual health plans.

(a) In general

The amendment made by subsection (a) requires that health plans in the individual market provide coverage according to this section in the same manner as group health plans in the group market.

(b) Effective dates

Subsection (b) provides for the applicability of the amendments with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

Section 6. Amendments to the Internal Revenue Code of 1986

Section 6 amends the Internal Revenue Code of 1986. This section is not within the jurisdiction of the Committee.

Section 7. Opportunity for independent, external third party reviews of certain non-renewals and discontinuations, including rescissions, of individual health insurance coverage

(a) Clarification regarding application of guaranteed renewability of individual health coverage

Subsection (a) amends section 2742(a) of the Public Health Service Act to provide that, except as provided in section 2742, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force, including without rescission, such coverage at the option of the individual.

In addition, subsection (a) amends section 2742(b) to provide that if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage, including the intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed, coverage may be non-renewed or not continued in force, including rescinded.

Subsection (a) also amends the heading of section 2742 to read "Guaranteed Renewability, Continuation in Force, Including Prohibition of Rescission, of Individual Health Insurance Coverage".

(b) Opportunity for independent, external third party review in certain cases

Subsection (b) adds a new section 2746 to the Public Health Service Act to specify that, before a nonrenewal, discontinuation of coverage, or rescission of coverage in the individual insurance market can take effect, the insurer shall provide the individual with an opportunity for independent, external third party review. If an individual requests such review, the coverage shall remain in effect until the independent, external third party determines that the coverage may be non-renewed, discontinued, or rescinded under Section 2742(b)(2), which specifies the fraud exclusion in guaranteed renewability and continuation in force, including prohibition of rescission.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

* * * * * * *

SUBTITLE B—OTHER REQUIREMENTS

* * * * * * *

SEC. 714. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

(A) except as provided for in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

(d) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d); or

(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage solely for the purpose of avoiding the requirements of this section.

* * * * * * *

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—GROUP MARKET REFORMS

* * * * * * *

Subpart 2—Other Requirements

* * * * * * *

SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

(A) insofar as the attending physician, in consultation with the patient, determines it to be medically necessary—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under this paragraph.

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature

or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

(d) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d); or

(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage solely for the purpose of avoiding the requirements of this section.

* * * * * * *

PART B—INDIVIDUAL MARKET RULES

Subpart 1—Portability, Access, and Renewability Requirements

* * * * * * *

SEC. 2742. GUARANTEED RENEWABILITY, *CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,* OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force*, including without rescission,* such coverage at the option of the individual.

(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) * * *

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage*, including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed*.

* * * * * * *

SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).

* * * * * * *

Subpart 2—Other Requirements

* * * * * * *

SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage

offered by a health insurance issuer in connection with a group health plan in the small or large group market.

* * * * * * *

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle K—Group Health Plan Requirements

* * * * * * *

CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

* * * * * * *

SUBCHAPTER B—OTHER REQUIREMENTS

* * * * * * *

* * * * * * *

SEC. 9813. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan may not—

(A) except as provided for in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or

(B) require that a provider obtain authorization from the plan for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination

by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

(1) in the next mailing made by the plan to the participant or beneficiary; or

(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

(d) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(e) PROHIBITION ON PENALTIES.—A group health plan may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d); or

(4) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this section.

* * * * * * *

○